Eugene Central Services
Risk Services

Elected Officials

Mayor and Council Payroll Reductions

(Effective July 1, 2013)

1. City of Eugene Elected Officials receive a stipend and the option to purchase health insurance through the City. The plan design and costs are based on the Non-Represented employee group.
2. Elected Officials pay the entire cost of their health insurance coverage
3. Payroll deductions are taken on a pre-tax basis, except when covering Domestic Partners who are not tax dependents.

Elected Official Monthly Med/Dent/Vis Rates:

	City Health Plan (PPO)	City Managed Care Plan (POS)	City Hybrid Plan (POS)
Individual	$737.29 /mo.	$508.23 /mo.	$470.59 /mo.
Two Party	$1,398.00 /mo.	$1,027.94 /mo.	$950.35 /mo.
Family	$1,949.85 /mo.	$1,500.65 /mo.	$1,387.60 /mo.

If you have questions, contact Benefits Staff in Risk Services at 682-5062.

COMPARISON OF BENEFITS*
FOR CITY OF EUGENE
NON-REPRESENTED EMPLOYEES

Effective July 1, 2013

Medical/Vision/Pharmacy coverage is administered by PacificSource Health Plans
Dental coverage is administered by Moda Health (formerly ODS)
City of Eugene Employee Benefits Website: www.eugene-or.gov/employeebenefits

BENEFITS – NON-REP	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
Note: Benefits described below for the health plan options assume plan members receive in-network services preauthorized by their City Managed Care Plan or City Hybrid Plan PCP or through the City Health Plan PPO.			
General Information			
Payroll Deduction	Individual: $58.99 per month Two-Party: $111.84 per month Family: $155.99 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $40.66 per month Two-Party: $82.24 per month Family: $120.06 per month Employees may Opt-Out of health insurance with proof of other coverage.	Individual: $18.83 per month Two-Party: $38.02 per month Family: $55.51 per month Employees may Opt-Out of health insurance with proof of other coverage.
Eligible Dependents	Spouse or domestic partner. Eligible children up to age 26 as long as they are not eligible to enroll in another employer-sponsored health plan, other than a group health plan of a parent.		
Benefit Levels	Preferred Provider Organization (PPO) plan, using the PacificSource Preferred PSN PPO network. Most benefit levels after the deductible are : ▪ In-Network provider: 80% of discounted rates; ▪ Non-Network provider: 50% of reasonable and customary charges.	Point of Service (POS) plan, using the PacificSource Prime PSN network. Benefits are paid at the highest level when provided or referred by your PCP and using in-network providers. Most Non-Network /Non-Referred provider benefits are 50% of reasonable and customary charges after co-pay.	Point of Service (POS) plan, using the PacificSource Prime PSN network. It is necessary for you and your covered dependents to choose a Primary Care Practitioner (PCP). Benefits are paid at the highest level when provided or referred by your PCP. Most Non-Network/Non-Referred provider benefits are 50% of reasonable and customary charges after co-pay.
PacificSource Service Area	Worldwide for emergencies. Service area for the PacificSource Preferred PSN and Prime PSN Networks includes all Oregon and Idaho counties. Also Pacific, Wahkiakum, Cowlitz, Clark, Skamania and Klickitat counties in Washington state. Members living outside the PacificSource network can receive in-network benefits through the Idaho Physician's Network, the Montana InterWest Health Network or the First Health Network. See Handbook for details.		
Choice of Physician	Any qualified physician. While in the service area, you must use a network provider or hospital to receive in-network benefits.	It is necessary for you and your covered dependents to choose a Primary Care Physician (PCP). For most services, you must use or be referred by your PCP to be paid at the highest benefit level. See the Benefit Handbook for exceptions.	It is necessary for you and your covered dependents to choose a Primary Care Physician (PCP). For most services, you must use or be referred by your PCP to be paid at the highest benefit level. See Benefit Handbook for exceptions.

BENEFITS – NON-REP	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
Calendar Year Medical and Dental Deductibles	All benefits paid after the deductible is met unless otherwise noted. Medical: $150 per person; $450 maximum per family. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: No deductible for medical coverage. Dental: $50 per person; $150 maximum per family.	All benefits paid after the deductible is met unless otherwise noted. Medical: $200 per person; $600 maximum per family. Dental: $50 per person; $150 maximum per family.
Out-of-Pocket Medical Maximum	$1,000 per person each calendar year, in addition to the deductible, for covered medical services. Once this limit has been met, eligible medical charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical services. Once this limit has been met, eligible medical charges are covered in full for remainder of calendar year.	$1,000 per person each calendar year for covered medical expenses. Once this limit has been met, eligible charges are covered in full for remainder of calendar year.
Out-of-Pocket Rx Maximum	Retail: $1,000 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.	Retail: $1,300 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.	Retail: $1,300 per person per calendar year for retail pharmacy. Once this limit has been met, eligible retail prescriptions will be covered in full. Mail-order prescriptions do not have an out of pocket maximum.
Annual Dental Benefit Maximum	$1,500* per person per calendar year, including the first calendar year of coverage. *Does not apply to essential dental benefits for members under age 16. See the Employee Benefits Handbook for details.		
Pre-existing Conditions (Does not apply to members under age 19 or for pregnancy related conditions)			
Open enrollment	If you have been enrolled for 6 consecutive months in one of the City's health plans, you may transfer at open enrollment without any pre-existing condition limitations.		
New Eligible Employees & Dependents	For members age 19 and older, benefits are limited to $2,000 during the first 6 months for illness or injuries for which you received treatment in the 90 days before coverage began. The exclusion period will be reduced by creditable coverage under another health plan.	No pre-existing condition limitations under the City Managed Care Plan.	No pre-existing condition limitations under the City Hybrid Plan.
Claims Filing	Claim forms may be submitted by either the patient or the provider.	No claim forms needed.	Claim forms may be submitted by either the patient or the provider.

BENEFITS – NON-REP	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
For more information contact:	PacificSource Health Plans – 541.225.2650 or 888.532.5332 (medical/vision/pharmacy) Moda Health - Portland Office: 888.217.2365 (dental) Risk Services Employee Benefits Program: 541.682.8868		
***This comparison of benefits summarizes the general benefits under each plan. It does not provide a full description of benefits. For further information please contact PacificSource for your medical, pharmacy or vision benefits, or Moda Health for your dental benefits.**			
Medical, Vision and Pharmacy Benefits – Administered by PacificSource Health Plans			
Physician Services			
Surgery/Delivery			
Inpatient	80% after deductible.	Covered in full.	80% after deductible.
Outpatient	100% no deductible for physician services. 80% after deductible for outpatient facility charges.	Surgery covered in full. $15 office visit co-pay if performed in physician's office. Outpatient facility charges covered in full.	$15 co-pay for professional services if performed in a physician's office. 80% after deductible for outpatient facility charges.
Office Visits	80% after deductible; 80% no deductible for treatment of accidental injury.	Covered in full after $15 co-pay per visit.	Covered in full after $15 co-pay per visit.
Hospital Visits	80% after deductible.	Covered in full.	80% after deductible.
Allergy Injections	80% after deductible.	Covered in full.	80% after deductible.
Hospital Services			
Semi-private Room and Board	80% after deductible. *Subject to compliance with utilization review.*	Paid in full after $100 co-pay per day ($500 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Emergency Care			
Within Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$100 co-pay per visit; waived if admitted.	$100 co-pay per visit; waived if admitted.
Outside of Service Area	80% after deductible for treatment of illness; 80% with no deductible for treatment of accidental injury.	$100 co-pay per visit; waived if admitted.	$100 co-pay per visit; waived if admitted.
Emergency Transportation	80% after deductible.	$50 per trip; waived if admitted. Air ambulance covered when preauthorized.	80% after deductible.
Outpatient Services			
CT Scans and MRI	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.	80% after deductible

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X-Ray, Lab Tests and Radiation Therapy	80% after deductible for illness; 80% no deductible for treatment of accidental injury.	Covered in full.	80% after deductible
Rehabilitation - Physical Therapy	80% after deductible if prescribed by physician.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr. (combined with Occupational & Speech Therapy). Must be preauthorized.	Covered in full after $15 co-pay. No deductible. Limited to 30 sessions/yr. (combined with Occupational & Speech Therapy). Must be preauthorized.
Occupational and Speech Therapy	80% after deductible for certain medical conditions if prescribed by physician.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr. (combined with Physical Therapy). Must be preauthorized.	Covered in full after $15 co-pay per session; limited to 30 sessions/yr (combined with Physical Therapy). Must be preauthorized. No deductible
Maternity Care			
Hospital Services including Caesarean Sections and Newborn Care	Covered the same as any other medical condition; routine hospital nursery care covered from date of birth; 100% after deductible for delivery at licensed birthing center	Covered in full for outpatient delivery. Inpatient delivery covered in full after $100 co-pay per day ($500 maximum per stay).	$100 co-pay then 80% (co-pay limited to 5 days)
Physician Hospital Services including Prenatal, Delivery and Postnatal Care of Mother and Child	80% after deductible.	Covered in full after $25 co-pay per pregnancy.	Covered in full after $15 co-pay per visit.
Preventive and Well-Care Services			
Periodic Physical Exams	Covered at 80% to a maximum benefit of $250; no deductible.	Covered in full after $15 co-pay per visit.	Covered in full after $15 co-pay per visit. No deductible
Well-Baby/Child Care	Covered at 80% during first 24 months, no deductible.	Covered in full after $15 co-pay per visit (subject to schedule).	Covered in full after $15 co-pay per visit. No deductible
Immunizations	Covered at 80% for adults and children; no deductible. Children under age 2 covered under Well-Baby/Child Care	Covered in full.	Covered in full. No deductible
Cancer Screenings and Gynecological Exams, including Colonoscopy, Mammography, Breast, Pap and Pelvic Exams	Covered at 80%, no deductible. Subject to schedule of eligibility.	Covered in full after $15 co-pay. Subject to schedule of eligibility.	Covered in full after $15 co-pay. Subject to schedule of eligibility. No deductible

BENEFITS – NON-REP	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
Other Medical Treatment			
Alternative Care	▪ Acupuncture: 80% after deductible. ▪ Chiropractor: 80% after deductible, limited to 52 visits a calendar year. ▪ Office visits to Licensed Naturopaths ($300 benefit max), Licensed Massage Therapists ($300 benefit max), and Registered Dietitians ($200 benefit max): 80% after deductible. Benefit maximums per calendar year as noted. No limitation on number of medically necessary visits.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopaths: $15 co-pay per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year.	Services of Licensed Chiropractors, Licensed Massage Therapists, Registered Acupuncturists & Registered Dieticians; and office visits to Licensed Naturopaths: $15 co-pay per visit, up to 12 visits combined for all types of alternative care providers (limited to one consultation with registered dietician) per calendar year. No deductible
Durable Medical Equipment	Rental covered at 80% after deductible when prescribed by a physician (up to the purchase price of rental).	Covered at 80%.	Covered at 80% . After deductible
Hearing Aids	Adults: 50% of eligible expenses covered after deductible, up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses after deductible, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.	Adults: 50% of eligible expenses covered up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.	Adults: 50% of eligible expenses covered after deductible up to a $500 maximum benefit during a 36-month period. Dependent Children: 80% of eligible expenses with no copay, up to a $4000 maximum during a 48-month period. Maximum adjusted January 1 of each year.
Hearing Analysis	80% after deductible if prescribed by a physician when medically necessary.	Routine hearing exams covered in full after $15 co-pay for children under age 18 once every 24 months when performed by PCP.	Routine hearing exams covered in full after $15 co-pay for children under age 18 once every 24 months when performed by PCP.
Home Health Care	Covered in full after deductible when provided by RN or registered physical therapist and prescribed by a physician.	Covered in full when preauthorized.	80% after deductible when preauthorized.
Hospice Care	Covered in full after deductible.	Covered in full when preauthorized. ($15,000 lifetime maximum)	80% after deductible when preauthorized. ($15,000 lifetime maximum)
Mental Health & Chemical Dependency Services, including Alcoholism	Covered the same as any other medical condition, and may be subject to deductible, coinsurance or copay, and limitations. See specific service type (for example, hospital or physician services) for coverage levels. Benefits provided in accordance with state and federal requirements.		

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Podiatrist	80% after deductible.	Covered in full after $15 co-pay for Non-routine foot care when preauthorized by a PCP.	Covered in full after $15 co-pay for Non-routine foot care when preauthorized by a PCP.
Prosthetic Devices (Pacemaker, artificial limb, etc.)	80% after deductible for devices replacing body functions.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises.	80% for initial device replacing body function when obtained while you are covered by this Plan and when need first arises. After deductible
Tobacco Cessation Treatment	Eligible expenses covered up to a $500 lifetime maximum benefit for members age 15 or older participating in a tobacco cessation program, and up to two quit attempts through the Quit for Life tobacco cessation program. No deductible required.		
Pharmacy			
Prescription Drugs	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Co-pay: Generic: 10% or $10 co-pay* Preferred: 20% or $15 co-pay* Non-Preferred: 25% or $25 co-pay* (*Whichever is greater)	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Receive up to 34-day supply (30-day supply for self-injectables) Co-pay: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay* (*Whichever is greater)	Retail No deductible and no claim form required. Show PacificSource Wallet ID Card at retail pharmacy to receive benefit. Receive up to 34-day supply (30-day supply for self-injectables) Co-pay: Generic: 50% co-pay Preferred: 50% co-pay Non-Preferred: $40 or 50% co-pay* (*Whichever is greater)
	Mail Order (Caremark or Wellpartner) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: 10% or $10 co-pay* Preferred: 20% or $15 co-pay* Non-Preferred: 25% or $25 co-pay* (*Whichever is greater)	Mail Order (Caremark or Wellpartner) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay	Mail Order (Caremark or Wellpartner) No deductible and no claim form required. Receive up to 90-day supply (30-day supply for self-injectables) Co-pay: Generic: $15 co-pay Preferred: $35 co-pay Non-Preferred: $70 co-pay

BENEFITS – NON-REP	City Health Plan (PPO) In-Network Benefit	City Managed Care Plan (POS) PCP/Referred In-Network Benefit	City Hybrid Plan** (POS) PCP/Referred In-Network Benefit
Vision			
Eye Exams	80% with no deductible once every 12 months.	Children under age 18: Covered in full after $15 co-pay once every 24 months. Adults covered at 80% with no deductible once every 12 months.	Children under age 18: Covered in full after $15 co-pay once every 24 months. Adults covered at 80% with no deductible once every 12 months.
Prescription frames lenses, and contacts	$150 maximum every 24 months.		
Dental* - Administered by Moda Health (formerly ODS) * The City's dental plan utilizes participating dentists who have contracts with Moda Health. Benefit levels for non-participating dental providers are based on the prevailing fee level for covered services.			
Moda Health Service Area	The Moda Health Delta Dental Premier Network includes all counties in Oregon. Members living outside of Oregon can receive in-network benefits through Moda Health's national affiliation with Delta Dental Plans Association.		
Calendar Year Dental Deductible	$50 per person; $150 maximum per family. All benefits paid after the deductible is met unless otherwise noted.		
Annual Benefit Maximums	$1,500* per person per calendar year, including the first calendar year of coverage. *Essential dental benefits for members under the age of 16 will not be subject to the annual dental maximum. See the Employee Benefits Handbook for details.		
Preventive Dental Care-Exams, Bite-Wing X-Rays, Fluoride, and Routine Cleaning	100% no deductible every 6 months.		
Fillings, Restorative Crowns, Denture Repairs	80% after $50 deductible.		
Initial and Replacement Dentures and Bridgework	50% after $50 deductible. Covered only if previous denture or bridgework is more than five years old, and teeth were removed while the covered person was eligible for coverage under this plan.		
Implants	50% after $50 deductible. Implant placement and removal once per lifetime per tooth space.		
Orthodontia	50% with no deductible. $2,000 lifetime maximum per covered person.		

City Hybrid Plan Additional Information

**Fixed dollar co-pays, prescription drug co-pays, and disallowed charges do not apply to the annual deductible or to the out-of-pocket maximum. Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum. The City Hybrid Plan will be administered under the same terms and conditions as the City Managed Care Plan.